UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Client Services Fax: 319-384-7213
Billing Fax: 319-356-0729

FSHD1 and FSHD2 REQUISITION

FOR UIDL USE ONLY: MRN# PATH#
FOR CLIENT USE ONLY: Requisition Date Completed by:

PART A – PATIENT INFORMATION – *Required*	**PART B – PROVIDER INFORMATION – *Required***
Patient Last Name:	Referring Institution:
Patient First Name:	Street:
Street:	City: St: Zip:
City: St: Zip:	Phone: Fax:
Phone: Fax:	Referring Physician:
Date of Birth: Gender: ☐ M ☐ F	Referring Physician Phone:

PART C - SPECIMEN INFORMATION (Complete the appropriate information below and attach pertinent clinical history).

Required ICD-10 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

TISSUE SOURCE/SITE: WHOLE BLOOD **DATE OF COLLECTION:** _____
10 mL required volume in pink top tube (EDTA)
Liquid DNA specimens are not acceptable for testing except for methylation studies or SMCHD1 sequencing; minimum DNA concentration 0.25 μg/μl in 50 μl

PART D – FSHD TESTING REQUEST

☐ Full Test Panel (see FSHD diagnostic workflow →)
or select the Individual Components being requested:
☐ Determine Allele Size and Haplotyping
☐ Methylation ☐ SMCHD1 sequence

1) By requesting this test, will the ordering physician assume responsibility for providing the patient with associated guidance and genetic counseling regarding the test results (*please circle a response*)? **Yes No**

2) Has the patient had prior testing for FSHD? **Yes** (*provide lab and date*): _____ **No** **Unknown**

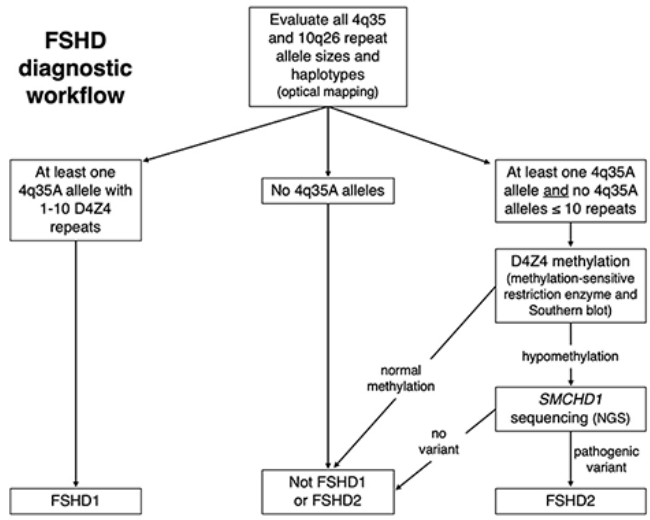
3) Does the patient have a 4q35 deletion? **Yes**. (*provide size of deleted 4q35 EcoRI fragment, if know*): _____ **No** **Unknown**

4) Has the patient undergone 4qA4qB allele testing? **Yes** **No** **Unknown**

5) Does the patient have one or more 4q35A alleles? **Yes** **No** **Unknown**

6) Does the patient have a family history of FSHD1 that has been confirmed by molecular genetic testing? **Yes** (*provide size of deleted 4q35 EcoRI allele, if known*): _____ **No** **Unknown**

7) Does the patient have a family history of FSHD2 that has been confirmed by molecular genetic testing? **Yes** (*provide SMCHD1 mutation, if known*): _____ **No** **Unknown**



SHIPPING INSTRUCTIONS: Ship on Mondays, Tuesdays or Wednesdays only, to avoid potential weekend deliveries.
Ship at refrigerated temperature Priority Overnight. DO NOT Freeze. **Contact UIDL prior to shipping.**
Preferably, send specimens -on the same day of collection- directly to us at UIDL, 200 Hawkins Drive, 5231 RCP, Iowa City, IA 52242-1087.

PART E –BILLING INFORMATION REQUIRED

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service is not "reasonable and necessary" under the Medicare standards although it would otherwise be covered, Medicare will deny payment for that service or test.

☐ ***Bill Referring Institution now***

☐ ***Bill 3rd party.*** ***See Page 2 for mandatory information.**

☐ ***HOLD testing until insurance coverage is determined by client.*** ***See Page 2 for mandatory information.**

☐ ***Bill Referring Institution only after client has determined insurance coverage.*** ***See Page 2 for mandatory information.**

☐ ***Bill Credit Card for all charges.*** ***See Page 2 to provide credit card information.**

**If the responsible billing party is not properly identified, and /or all billing requirements have not been met by the referring entity at the time of specimen arrival, the UIDL will process the submitted specimen to maintain the integrity of the sample for future testing. The Molecular Pathology Laboratory will store specimens. If the responsible billing party cannot be determined, and all billing requirements have not been met after 6 months, the test order itself will be canceled.*

BILLING OPTIONS –IF Bill Referring Institution now is NOT checked on page 1, completion of this section is MANDATORY.
Failure to fully vet coverage and comply will delay testing and render the referring institution liable for all charges incurred.

Section 1: Requirements for the UIDL to bill a 3rd party payer

Patients and/or Referring Physicians are responsible for screening for 3rd party payer coverage including whether prior authorization is needed and whether the patient has out of network benefits which will allow payment to the UIDL. The payer will need the following information:

UIDL Tax ID #426004813
UIDL NPI #1811984636
CPT codes and insurance charges for each component of FSHD 1 & 2 Panel testing (full panel may not be performed depending on results)

Determine Allele Sizes and Haplotyping	CPT 81404	$1,365	The Z code for this testing is **ZB5J4**.
Methylation	CPT 81479	$652	
SMCHD1	*CPT 81479*	$1,293	
Professional Interpretation	CPT 81404	$137	

If prior authorization is required, it must be obtained and the authorization # sent with the case.
If a gap exception is required to release out of network benefits, it must be obtained and the information sent with the case.
Medicare: All Medicare Cases must be accompanied by a fully executed ABN. *Should Option 2 in Section G of the CMS ABN, patient would be responsible for charges ranging from $874 minimum - $2004 maximum to be covered by a credit card. See Section 2 below.*
Medicaid: UIDL providers are only authorized Medicaid providers in the state of Iowa. UIDL is not able to file Medicaid claims outside of Iowa.

☐ **Bill 3rd party**, Attach Policy and Coverage details. (completion of Section 2 below is not necessary)
Prior Authorization Needed? ☐ No or ☐ Yes. Prior Auth # _____
UIDL in network with payer? ☐ Yes or ☐ No, but there are Out of Network Benefits
For Out of Network Benefits, a Gap Exception either was not required, or it was and is attached ☐ Yes or ☐ N/A

☐ **Hold testing and 3rd party billing until insurance coverage has been determined.** (completion of Section 2 below is not necessary)
Attachment of Policy details is still required at this time.

☐ **3rd party benefits are not available / 3rd party billing is not an option / UIDL will not file 3rd party payer claims. Complete section 2.**

Section 2: Provide credit card information

If the requirements for 3rd party billing cannot be met and the referring institution is not to be billed, credit card information **MUST** be provided to the UIDL prior to sending the specimen or be included with the specimen.

☐ **Input valid credit card information here:**
☐ Visa ☐ MC ☐ DiscoverCard #_____-_____-_____-_____ Expires____/_____ Pin # _____
Cardholder Name (Print last name, firstname): _____

Cardholder Email: _____ Cardholder phone#: _____

☐ **Provide credit card information by phone (**prior to sending the specimen).
Call 319-353-7958 between the hours of 8:00 AM-4:30 PM CST M-F
Payment Date done by phone___/___/____ Name of UIDL staff person that Credit Card information was given to:_____

How much will be charged to the credit card or be billed to a referring institution?

$874 minimum – $2,004 maximum
The *minimum* amount of work that is usually ordered includes the Determine Allele Sizes and Haplotyping with Professional Interpretation. The charge for that amount of work is $874. The Full Test Panel is not required; providers must be specific on the Test Requisition whether the full panel or individual components are being requested. The *maximum* charge for all possible testing is $2,004.

Pricing is Subject to Change

If the specimen collection needs to be done at a later date or from another location more convenient for the patient, please email **UIDL Client Services <UIDLClientServices@healthcare.uiowa.edu>** for a complimentary collection and transport kit.

Please refer to the UIDL Test Directory for further details: FSHD - Detection of Abnormal Alleles with Interpretation (FSHD1 and FSHD2) and Facioscapulohumeral Dystrophy (FSHD) Information (FSHD1 and FSHD2)